

		FOR OHF USE					

LL 1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0011544</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>Meadows Mennonite Home</u>		<p>I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2001</u> to <u>12/31/2001</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</p> <p>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</p>																									
Address: <u>Rural Route # 1</u> <u>Chenoa</u> <u>61726</u>																											
County: <u>McLean</u>																											
Telephone Number: <u>(309) 747-2702</u> Fax # <u>(309) 747-2944</u>																											
IDPA ID Number: <u>370791831001</u>																											
Date of Initial License for Current Owners: <u>1958</u>		<div>Officer or Administrator of Provider</div> <div>(Signed) _____ (Date) _____</div> <div>(Type or Print Name) _____</div> <div>(Title) _____</div>																									
Type of Ownership:																											
<table><tr><td><input checked="" type="checkbox"/> VOLUNTARY,NON-PROFIT</td><td><input type="checkbox"/> PROPRIETARY</td><td><input type="checkbox"/> GOVERNMENTAL</td></tr><tr><td><input checked="" type="checkbox"/> Charitable Corp.</td><td><input type="checkbox"/> Individual</td><td><input type="checkbox"/> State</td></tr><tr><td><input type="checkbox"/> Trust</td><td><input type="checkbox"/> Partnership</td><td><input type="checkbox"/> County</td></tr><tr><td></td><td><input type="checkbox"/> Corporation</td><td><input type="checkbox"/> Other _____</td></tr><tr><td></td><td><input type="checkbox"/> "Sub-S" Corp.</td><td>_____</td></tr><tr><td></td><td><input type="checkbox"/> Limited Liability Co.</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Trust</td><td></td></tr><tr><td></td><td><input type="checkbox"/> Other _____</td><td></td></tr></table>		<input checked="" type="checkbox"/> VOLUNTARY,NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County		<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.	_____		<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		<div>Paid Preparer</div> <div>(Signed) <u>SEE ACCOUNTANTS' COMPILATION REPORT</u> (Date) _____</div> <div>(Print Name and Title) _____</div> <div>(Firm Name & Address) <u>Altschuler, Melvoin and Glasser LLI</u> <u>One South Wacker Drive, Suite 800, Chicago, IL 60606</u></div> <div>(Telephone) <u>(312) 634-3400</u> Fax : <u>(312) 634-5518</u></div>	
<input checked="" type="checkbox"/> VOLUNTARY,NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
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	<input type="checkbox"/> "Sub-S" Corp.	_____																									
	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact Name: <u>Mike Kaplan</u> Telephone Number: <u>(312) 634-3400</u> Please send copies of desk review and audit adjustments to address on this page																											

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Page 2

Facility Name & ID Number Meadows Mennonite Home# 0011544Report Period Beginning: 01/01/2001Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed bedsN/A

1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period
1	22	Skilled (SNF)	22	8,030
2		Skilled Pediatric (SNF/PED)		
3	108	Intermediate (ICF)	108	39,420
4		Intermediate/DD		
5	29	Sheltered Care (SC)	29	10,585
6		ICF/DD 16 or Less		
7	159	TOTALS	159	58,035

B. Census-For the entire report period.

1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment			
		Public Aid Recipient	Private Pay	Other	
8	SNF	3,228	4,347		7,575
9	SNF/PED				
10	ICF	12,266	23,974		36,240
11	ICF/DD				
12	SC	487	2,883		3,370
13	DD 16 OR LESS				
14	TOTALS	15,981	31,204		47,185

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.)81.30%

D. How many bed-hold days during this year were paid by Public Aid?None(Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?YESNONon-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?YESNON

I. On what date did you start providing long term care at this locationDate started1958

J. Was the facility purchased or leased after January 1, 1978?YESNON

K. Was the facility certified for Medicare during the reporting year?YESNONIf YES, enter number of beds certified0and days of care providedN/A

Medicare IntermediaryN/A

IV. ACCOUNTING BASIS

ACCRUALMODIFIEDCASH*CASH*

Is your fiscal year identical to your tax yearYESNON

Tax Year: 12/31/2001Fiscal Year: 12/31/2001

* All facilities other than governmental must report on the accrual basis

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		Meadows Mennonite Home		# 0011544		Report Period Beginning:		01/01/2001		Ending: 12/31/2001	
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)											
	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	313,745	15,460	2,046	331,251		331,251		331,251		1
2	Food Purchase		298,090		298,090		298,090	(291)	297,799		2
3	Housekeeping	203,680	30,248	873	234,801		234,801		234,801		3
4	Laundry	36,379	9,581	17,349	63,309		63,309		63,309		4
5	Heat and Other Utilities			188,791	188,791		188,791		188,791		5
6	Maintenance	80,398	16,427	84,761	181,586		181,586		181,586		6
7	Other (specify):*										7
8	TOTAL General Services	634,202	369,806	293,820	1,297,828		1,297,828	(291)	1,297,537		8
	B. Health Care and Programs										
9	Medical Director			4,800	4,800		4,800		4,800		9
10	Nursing and Medical Records	1,697,527	99,574	511,500	2,308,601		2,308,601		2,308,601		10
10a	Therapy			19,318	19,318		19,318		19,318		10a
11	Activities	111,931	3,962	2,025	117,918		117,918	(2,023)	115,895		11
12	Social Services	106,431	1,464		107,895		107,895		107,895		12
13	Nurse Aide Training	5,002		2,315	7,317		7,317		7,317		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	1,920,891	105,000	539,958	2,565,849		2,565,849	(2,023)	2,563,826		16
	C. General Administration										
17	Administrative	123,523			123,523		123,523		123,523		17
18	Directors Fees										18
19	Professional Services			44,263	44,263		44,263		44,263		19
20	Dues, Fees, Subscriptions & Promotion			19,928	19,928		19,928		19,928		20
21	Clerical & General Office Expense	216,859	13,660	47,430	277,949		277,949	(13,378)	264,571		21
22	Employee Benefits & Payroll Tax			564,957	564,957		564,957		564,957		22
23	Inservice Training & Educator			200	200		200		200		23
24	Travel and Seminar			24,746	24,746		24,746	(7,314)	17,432		24
25	Other Admin. Staff Transportatior			7,582	7,582		7,582		7,582		25
26	Insurance-Prop.Liab.Malpractice			36,486	36,486		36,486		36,486		26
27	Other (specify):*										27
28	TOTAL General Administration	340,382	13,660	745,592	1,099,634		1,099,634	(20,692)	1,078,942		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,895,475	488,466	1,579,370	4,963,311		4,963,311	(23,006)	4,940,305		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

SEE ACCOUNTANTS' COMPILATION REPORT

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7**	8			
30	Depreciation			361,018	361,018		361,018	(15,102)	345,916			30
31	Amortization of Pre-Op. & Org											31
32	Interest			143,822	143,822		143,822	(16,572)	127,250			32
33	Real Estate Taxes			31,704	31,704		31,704	(31,704)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicle:			760	760		760		760			35
36	Other (specify): ⁴											36
37	TOTAL Ownership			537,304	537,304		537,304	(63,378)	473,926			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportatior											38
39	Ancillary Service Center:											39
40	Barber and Beauty Shops	3,521			3,521		3,521		3,521			40
41	Coffee and Gift Shop:											41
42	Provider Participation Fec			71,175	71,175		71,175		71,175			42
43	Other (specify): ⁴ Nonallowable costs	127,065	2,939	179,626	309,630		309,630	(309,630)				43
44	TOTAL Special Cost Centers	130,586	2,939	250,801	384,326		384,326	(309,630)	74,696			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	3,026,061	491,405	2,367,475	5,884,941		5,884,941	(396,014)	5,488,927			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

**See schedule of adjustments attached at end of cost report

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals	(291)	2		4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patient				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(15,102)	30		9
10	Interest and Other Investment Incom	(16,572)	32		10
11	Discounts, Allowances, Rebates & Refund				11
12	Non-Working Officer's or Owner's Salar				12
13	Sales Tax				13
14	Non-Care Related Interes				14
15	Non-Care Related Owner's Transaction				15
16	Personal Expenses (Including Transportation				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individual:				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona				25
26	Income Taxes and Illinois Persona Property Replacement Tax				26
27	Nurse Aide Training for Non-Employee				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Sch 5a	(364,049)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (396,014)		\$	30

OHF USE ONLY							
48		49		50		51	52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule'	\$		31
32	Donated Goods-Attach Schedule'			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (396,014)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification.
(See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	\$		38
39						39
40	Gift and Coffee Shop:		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name

PROVIDER #

Period Ending

Meadows Mennonite Home001154412/31/2001

Schedule 5A

VI. ADJUSTMENT DETAIL
LINE 29 - Other

Description	Amount	Schedule V Reference
Activity Income Offset	(2,023)	11
Miscellaneous Income Offset	(13,378)	21
Out of State Travel	(5,767)	24
Non-Patient Care Real Estate Taxes	(31,704)	33
Non-Allowable Cottage and Resident Expenses	(302,066)	43
CEO Housing	(2,314)	43
Development Department Travel & Seminar	(1,547)	24
Non-Allowable Intercompany Interest	(5,250)	43
Total	(364,049)	

See Accountants' Compilation Report

Meadows Mennonite Home

Report Period Beginning:

Ending:

ID#

0011544

01/01/2001

12/31/2001

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1		\$	1
2			2
3			3
4			4
5			5
6			6
7			7
8			8
9			9
10			10
11			11
12			12
13			13
14			14
15			15
16			16
17			17
18			18
19			19
20			20
21			21
22			22
23			23
24			24
25			25
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	0	49

Summary A

0011544

01/01/2001

Ending:

12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
				Meadows Mennonite Retirement Home	Meadows	Independent Living Housing

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			\$			\$		1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

Facility Name

Provider #

Period Ending

Meadows Mennonite Home

0011544

12/31/2001

VI. Related Parties

Schedule 6a

BOARD OF TRUSTEES

Paul Watkins Chairman Bloomington, IL	John McDonald Morton, IL
Roger Gundy Vice Chairman Flanagan, IL	Helen Roth Gridley, IL
Kathy Trachsel Secretary Chenoa, IL	Rody Vercler Washington, IL
Keith Mikel Treasurer Chenoa, IL	Del Moran Fairbury, IL

Note:

No board member nor entity owned by board member provided services to the facility.

See Accountants' Compilation Report

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2	N/A										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

SEE ACCOUNTANTS' COMPILATION REPORT

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.)

YES ☐

NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization

Street Address

City / State / Zip Code

Phone Number

Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2		N/A								2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	GMAC		x	Mortgage	\$8,319.00	6/1976	\$ 1,620,000	\$ 830,368	6/2016	0.0500	\$ 43,175	1							
2	FMHA		x	Mortgage	\$9,876.00	2/1996	1,782,500	1,657,998	3/2028	0.0500	83,757	2							
3	Heartland Bank		x	Mortgage	\$13,871.00	1/1996	1,500,000		2/2002	0.0875	79	3							
4	Newcourt Leasing		x	Copier	\$220.00	5/97	8,000		6/30/01	0.2000	322	4							
5	See Schedule 9A				\$1,965.00		517,116	454,152			3,952	5							
	Working Capital																		
6	Heartland Bank		x	Line of Credit		6/30/00	200,000	200,000	6/30/02	0.0760	12,537	6							
7												7							
8												8							
9	TOTAL Facility Related				\$34,251.00		\$ 5,627,616	\$ 3,142,518				\$ 143,822	9						
	B. Non-Facility Related*																		
10												10							
11	Interest Income Offset										(16,572)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$				\$ (16,572)	14						
15	TOTALS (line 9+line14)						\$ 5,627,616	\$ 3,142,518				\$ 127,250	15						

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name Meadows Mennonite Home
PROVIDER # 0011544
Period Ending 12/31/2001

Schedule 9A
INTEREST EXPENSE

See Accountants' Compilation Report

Name of Lender	Related		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense
	YES	NO				Original	Balance			
A. Directly Facility Related										
Long-Term										
Loyalty Loans		x	Prior Expansion		5/28/2005	\$ 13,500.00	\$ 13,500.00	N/A	0.0750	\$ 910.00
Commerce Bank		x	Auto Loan	\$377.00	11/1/1998	15,701.00	3,295.00	9/1/2003	0.0714	396.00
Heartland Bank		x	Auto Loan	\$586.00	2/1/1999	29,000.00	957.00	2/1/2004	0.0790	333.00
Heartland Bank		x	Computer Upgrade	\$1,002.00	4/1/1999	50,000.00	25,796.00	4/1/2004	0.0750	2,313.00
Heartland Bank		x	Construction Loan		9/14/2001	408,915.00	410,604.00	12/14/2002	0.0750	
Working Capital										
TOTAL Facility Related				1,965.00		\$ 517,116.00	\$ 454,152.00			\$ 3,952.00
B. Non-Facility Related										
TOTAL Non-Facility Related						\$ 0.00	\$ 0.00			\$ 0.00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		<div>Important, please see the next worksheet, "RE_Tax". The real estate tax statement and t must accompany the cost report</div>	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).			\$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru			\$	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1996	8		
	1997	9		
	1998	10		
	1999	11		
	2000	12		

FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000 \$	13
14	PLUS APPEAL COST FROM LINE 5 \$	14
15	LESS REFUND FROM LINE 6 \$	15
16	AMOUNT TO USE FOR RATE CALCULATIONS\$	16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.

2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Meadows Mennonite Home COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0011544

CONTACT PERSON REGARDING THIS REPORT Roger Hasler

TELEPHONE (309) 747-2702 FAX #: (309) 747-2944

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
			<u>Tax</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Applicable to</u>
			<u>Nursing Home</u>
1.		\$	\$
2.	N/A	\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:

76,955

B. General Construction Type:

Exterior

Masonry

Frame

Wood, Brick, Steel

Number of Stories

2

C. Does the Operating Entity?

☒

(a) Own the Facility

☐

(b) Rent from a Related Organization

☐

(c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity?

☒

(a) Own the Equipment

☐

(b) Rent equipment from a Related Organization

☒

(c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

Meadows Mennonite Retirement Home

Independent Living Housing

F. Does this cost report reflect any organization or pre-operating costs which are being amortizee

☐

YES

☒

NO

If so, please complete the following:

1. Total Amount Incurred:

N/A

2. Number of Years Over Which it is Being Amortized

N/A

3. Current Period Amortization:

N/A

4. Dates Incurred:

N/A

Nature of Costs:

N/A

(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Facility	683,400	1920	\$ 15,065	1
2	Facility		1950	27,033	2
3	TOTALS	683,400		\$ 42,098	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1923	1923	\$ 74,144	\$		\$	\$	\$	4
5	23		1952	1952	86,314						5
6	25		1966	1966	225,617						6
7	94		1978	1978	2,348,846						7
8	17		1997	1997	3,898,385						8
	Improvement Type**										
9	Various Building Improvements			1979	119,175						9
10	Various Building Improvements			1980	17,129						10
11	Various Building Improvements			1981	13,566						11
12	Various Building Improvements			1982	1,645	NOTE: DETAIL UNAVAILABLE					12
13	Various Building Improvements			1983	217,187						13
14	Various Building Improvements			1984	6,839						14
15	Various Building Improvements			1985	31,287						15
16	Various Building Improvements			1986	14,477						16
17	Various Building Improvements			1987	15,979						17
18	Various Building Improvements			1988	8,451						18
19	Various Building Improvements			1989	24,261						19
20	Various Building Improvements			1990	5,948						20
21	Various Building Improvements			1991	10,093						21
22	Various Building Improvements			1992	42,794						22
23	Various Building Improvements			1993	28,059						23
24	Various Building Improvements			1994	94,725						24
25	Various Building Improvements			1995	48,021						25
26	Engineering Cad & Survey			1996	675						26
27	Excavating			1996	2,000						27
28	Boiler Repair - Cleveland			1996	503						28
29	Roof A/C Repair			1996	718						29
30	Window Coverings			1996	1,039						30
31	Sewage Pump Repairs			1996	1,685						31
32	Siding			1997	22						32
33	Siding			1997	245						33
34	Carpet			1997	1,090						34
35	Windows			1997	607						35
36	2 Patios			1997	770						36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1		3	4	5	6	7	8	9	
Improvement Type**		Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Landscaping	1997	\$ 957	\$		\$	\$	\$	37
38	Glass	1997	677						38
39	Service-Intercom System Repairs	1997	871						39
40	Fiber Optics - Computer Wiring	1997	2,887						40
41	Liquid Storage Cabinet Tank	1997	572						41
42	Paging System- Bennett	1997	2,288						42
43	Install Heating & Cooling	1997	15,161						43
44	Compressors	1997	692						44
45	Compressors	1997	961						45
46	Window Blinds	1997	1,539	NOTE: DETAIL UNAVAILABLE					46
47	Motor A/C Motor & Starter for 2 Ton Unit	1997	715						47
48	Repair Cool	1997	421						48
49	Repair Cool	1997	328						49
50	2 Roof top Units	1997	1,295						50
51	A/C Part Repairs	1997	733						51
52	Power Server	1997	150						52
53	Labor & Installation Units Rooftop A/C	1997	19,250						53
54	2 Carrier Heating & Cooling	1997	19,250						54
55	Intercom Wiring Repairs	1997	696						55
56	Carousel Tub	1997	12,423						56
57	Landscaping	1997	30,518						57
58	Curtains, Valances	1997	10,077						58
59	Patio Garden Landscaping	1997	12,842						59
60	Fence & Gate	1997	10,162						60
61	Telephone Wiring	1997	1,462						61
62	Draperies - Clark	1997	869						62
63	ASI Sign System	1997	2,547						63
64	Rocks For 2 Courtyards	1998	2,070						64
65	Asphalt Maintenance	1998	5,500						65
66	Window Room # 51	1998	444						66
67	Magnetic Gate Contact	1998	228						67
68	Carpet Restroom	1998	330						68
69	Carpet 3 Rooms	1998	793						69
70	TOTAL (lines 4 thru 69)		\$ 7,502,504	\$		\$	\$	\$	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,502,504	\$		\$	\$	\$	1
2	Maintenance Shop	1998	909						2
3	2 A/C Compressors	1998	1,006						3
4	Heat & Air Thermostat	1998	1,410						4
5	Natural Gas Steamer	1998	7,495						5
6	Heat Duct Repair	1998	761						6
7	Repair Engine & Generator	1998	1,322						7
8	Alarm System Phase I	1998	44,529						8
9	Sewage Pump Rehab	1998	7,208	NOTE: DETAIL UNAVAILABLE					9
10	Water Tower Rehab	1998	63,699						10
11	OSHA Upgrades	1998	111						11
12	Required OSHA Items	1998	458						12
13	Eye Wash Station	1998	585						13
14	1 CS Spill Kits	1998	122						14
15	Repair Roadway	1999	3,500						15
16	Landscaping Improvements	1999	2,259						16
17	Station 1 Door Keypads	1999	1,442						17
18	Station 1 Code Alert System	1999	15,298						18
19	Station 1 Nurse Call System	1999	11,924						19
20	Ceiling Installation	1999	1,945						20
21	Improvements to Brown Shed	1999	1,288						21
22	Safety Bars in Alzheimer's Unit	1999	2,350						22
23	Bronze Door & Closer	1999	1,806						23
24	Hardware for Existing Doors in Alzheimer's Unit	1999	5,536						24
25	Sensor Base for Alarm	1999	231						25
26	Repair Boiler Station 4	1999	1,140						26
27	Repair Generator	1999	3,067						27
28	Water Heater for Kitchen	1999	878						28
29	Panic Devices on Doors in Alzheimer Unit	1999	688						29
30	Alarm System	1999	7,562						30
31	Storage Cabinets & Installation	1999	5,242						31
32	Elevator Eye	1999	1,978						32
33	Fire Alarm System Materials & Labor	1999	27,650						33
34	TOTAL (lines 1 thru 33)		\$ 7,727,903	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,727,903	\$		\$	\$	\$	1
2	Compressor for Freezer	1999	1,809						2
3	Sewer Improvements (Check Valves)	1999	1,312						3
4	New Pipes in Well	1999	921						4
5	New Alzheimer Unit Sign	1999	1,144						5
6	Station 4 Door Seal Parts & Labor	1999	1,163						6
7	Carpet - Station 5	2000	1,126						7
8	Station 5 Remodel	2000	320						8
9	Station 5 Tile	2000	530						9
10	Bathroom Fixtures - Station 5	2000	1,675	NOTE: DETAIL UNAVAILABLE					10
11	Garage Door Enlargement	2000	1,276						11
12	Elevator Cylinder	2000	16,746						12
13	Fire Alarm System	2000	18,000						13
14	Mastercare Hydrobath	2000	9,490						14
15	Door Locks on Soiled Linen Closet	2000	568						15
16	Air Conditioner Motor	2000	657						16
17	Air Conditioner Compressor	2000	1,732						17
18	Alarm System	2000	35,000						18
19	Alarm System	2000	18,060						19
20	Alarm System Sensor	2000	864						20
21	Premium Lawn	2000	755						21
22	Parking Lot Addition	2000	7,355						22
23	New Controller for Sewer	2000	1,573						23
24	Sewer Improvements	2000	752						24
25	Water Main Work	2000	2,203						25
26	Water Main Extension	2000	8,465						26
27	Chlorinator	2000	1,389						27
28	Generator Repair	2001	506						28
29	Generator Repair/Trans	2001	1,434						29
30	Boiler Repair	2001	1,044						30
31	Air Conditioner Compressor	2001	700						31
32	Air Conditioner Compressor	2001	1,200						32
33	Storm Windows	2001	2,071						33
34	TOTAL (lines 1 thru 33)		\$ 7,869,743	\$		\$	\$	\$	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,869,743	\$		\$	\$	\$	1
2	Simplex Fire Alarm	2001	763						2
3									3
4									4
5	NOTE: DETAIL UNAVAILABLE			265,510		265,510		3,402,616	5
6									6
7									7
8									8
9									9
10				NOTE: DETAIL UNAVAILABLE					10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,870,506	\$ 265,510		\$ 265,510	\$	\$ 3,402,616	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 500,611	\$ 77,728	\$ 77,728	\$	3- 25 yrs	\$ 278,467	71
72	Current Year Purchases	38,636	2,678	2,678		3 - 7 yrs	2,678	72
73	Fully Depreciated Assets	538,983				Various	538,983	73
74								74
75	TOTALS	\$ 1,078,230	\$ 80,406	\$ 80,406	\$		\$ 820,128	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		N/A		\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Asset

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,990,834	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 345,916	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 345,916	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 4,222,744	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Residential Housing Units	\$ 1,350,806	\$ 34,361	\$ 749,745	86
87	Residential Vehicles	90,892	15,102	53,767	87
88	CEO House Remodeling	70,602	2,314	28,093	88
89	Land	175,524			89
90					90
91	TOTALS	\$ 1,687,824	\$ 51,777	\$ 831,605	91

G. Construction-in-Progres

	Description	Cost	
92	Building PhaseII	\$ 505,001	92
93			93
94			94
95		\$ 505,001	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column f

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. YES NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A.

9. Option to Buy: YES x NO Terms: N/A *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? YES NO x

16. Rental Amount for movable equipment: \$ 760 Description: Dishwasher

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
Beginning N/A
Ending N/A

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	\$ N/A
13.	/2003	\$ N/A
14.	/2004	\$ N/A

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☒ YES
☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM☐

IN OTHER FACILITY☒

COMMUNITY COLLEGE☐

HOURS PER AIDE112

3. CLINICAL PORTION:

IN-HOUSE PROGRAM☒

IN OTHER FACILITY☐

HOURS PER AIDE40

B. EXPENSES

		ALLOCATION OF COSTS (d)			
		1	2	3	4
		Facility		Contract	Total
		Drop-outs	Completed		
1	Community College Tuition	\$ 300	\$ 1,730		\$ 2,030
2	Books and Supplies	45	90		135
3	Classroom Wages (a)	573	4,429		5,002
4	Clinical Wages (b)				
5	In-House Trainer Wage: (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		150		150
9	TOTALS	\$ 918	\$ 6,399		\$ 7,317
10	SUM OF line 9, col. 1 and 2 (e)	\$ 7,317			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefit;
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefit;
- (c) For in-house training programs only. Do not include fringe benefit;
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities:

\$None

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	6

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
	Licensed Speech and Language Development Therapist		hrs							2
2	Licensed Recreational Therapist		hrs							3
3	Licensed Physical Therapist		hrs							4
4	Physician Care		visits							5
5	Dental Care		visits							6
6	Work Related Program		hrs							7
7	Habilitation		hrs							8
8	Pharmacy		# of prescripts							9
9	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12	Other (specify):									13
13										
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed
Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be lis
on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 843,416	\$ 843,416	1
2	Cash-Patient Deposits	14,592	14,592	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance <u>None</u>)	258,683	258,683	3
4	Supply Inventory (priced at <u> </u>)			4
5	Short-Term Investments			5
6	Prepaid Insurance	96,311	96,311	6
7	Other Prepaid Expenses	33,743	33,743	7
8	Accounts Receivable (owners or related parties)	11,213	11,213	8
9	Other(specify): <u>Show Bus NonPatient Care</u>	34,344		9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,292,302	\$ 1,257,958	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	622,140	622,140	12
13	Land	217,622	42,098	13
14	Buildings, at Historical Cost	8,671,460	7,870,506	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,432,744	1,078,230	16
17	Accumulated Depreciation (book methods)	(4,276,511)	(4,222,744)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
	Accumulated Amortization -			
20	Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (sp See Sch 17A <u> </u>)	1,148,571	505,001	22
23	Other(specify): <u> </u>			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 7,816,026	\$ 5,895,231	24
	TOTAL ASSETS			
25	(sum of lines 10 and 24)	\$ 9,108,328	\$ 7,153,189	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 75,082	\$ 75,082	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	18,285	18,285	28
29	Short-Term Notes Payable	321,507	321,507	29
30	Accrued Salaries Payable	134,211	134,211	30
	Accrued Taxes Payable			
31	(excluding real estate taxes)	(29)	(29)	31
32	Accrued Real Estate Taxes(Sch.IX-B)	31,700		32
33	Accrued Interest Payable	29,367	29,357	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>See Schedule 17A</u>	276,987	276,987	36
37	<u>Showbus Payables</u>	10	10	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 887,120	\$ 855,410	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	427,071	427,071	39
40	Mortgage Payable	2,393,940	2,393,940	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	<u>NonPatient Care Notes</u>	873,722		43
44	<u> </u>			44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 3,694,733	\$ 2,821,011	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 4,581,853	\$ 3,676,421	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,526,475	\$ 3,476,768	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 9,108,328	\$ 7,153,189	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

Facility Name Meadows Mennonite Home
PROVIDER # 0011544
Period Ending 12/31/2001

Schedule 17A

XV. BALANCE SHEET

A. Other Long-Term Assets			
Line 22, Other (specify)		Operating	After Consolidation
Construction in Progress		505,001	505,001
Rental Property		601,061	
CEO Housing Remodeling		42,509	
Other			
Total		1,148,571	505,001

C. Current Liabilities			
Line 36, Other Current Liabilities (specify):		Operating	After Consolidation
Health Insurance		44,516	44,516
Sick/Bonus/Christmas		23,000	23,000
Cookbook/Fundraising		7	7
ETO / Bonus' Payable		194,141	194,141
403(b) Annuity		14,313	14,313
Section 125 Medical Expenses		(70)	(70)
Trust Application Deposit		1,080	1,080
Total		276,987	276,987

SEE ACCOUNTANTS' COMPILATION REPORT

		I Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,718,350	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,718,350	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(191,870)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (191,870)	17
	B. Transfers (Itemize):		
18	Rounding	(5)	18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (5)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,526,475	24 *

Operating entity only
* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expenses

1			
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 5,653,136	1
2	Discounts and Allowances for all Levels	(595,001)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 5,058,135	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	22,127	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 22,127	8
	C. Other Operating Revenue		
9	Payments for Educator		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursement		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	7,720	13
14	Non-Patient Meals	291	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	97,917	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 105,928	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	21,822	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 21,822	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19A	485,059	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 485,059	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 5,693,071	30

2			
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,297,828	31
32	Health Care	2,565,849	32
33	General Administration	1,099,634	33
	B. Capital Expense		
34	Ownership	537,304	34
	C. Ancillary Expense		
35	Special Cost Centers	313,151	35
36	Provider Participation Fee	71,175	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 5,884,941	40
41	Income before Income Taxes (line 30 minus line 40)**	(191,870)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (191,870)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name Meadows Mennonite Home
PROVIDER # 0011544
Period Ending 12/31/2001

Schedule 19 A

XVII. INCOME STATEMENT

E. Other Revenue

	Amount
Residential	323,420
Admission Fees	8,250
Wanderguard	3,352
Designated - Memorials	20,474
Designated - Other	11,170
Undesignated - Memorials	6,521
Undesignated - Other	15,593
Estate and Trust Contributions	28,509
Gifts in Kind	9,577
Gain on Sale of Investment	800
Resident Assistance	1,888
Property Damage	39,281
Miscellaneous	3,657
Administrative Services Reimbursement	6,534
CFO Reimbursement	3,120
Activity Crafts Income	2,023
Telephone & Fax Income	67
Cookbook Income	113
Rental Income	710
Total	485,059

See Accountants' Compilation Report

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,024	2,080	\$ 43,325	\$ 20.83	1
2	Assistant Director of Nursing	1,792	2,018	39,114	19.38	2
3	Registered Nurses	14,271	15,692	291,565	18.58	3
4	Licensed Practical Nurses	20,061	22,854	334,295	14.63	4
5	Nurse Aides & Orderlies	86,253	95,829	946,877	9.88	5
6	Nurse Aide Trainees	456	506	5,002	9.89	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,476	1,751	18,540	10.59	8
9	Activity Director	1,961	2,412	24,318	10.08	9
10	Activity Assistants	10,329	11,149	87,613	7.86	10
11	Social Service Worker	3,896	4,175	60,353	14.46	11
12	Dietician					12
13	Food Service Supervisor	2,835	2,978	46,982	15.78	13
14	Head Cook	9,148	10,010	87,541	8.75	14
15	Cook Helpers/Assistants	24,170	26,065	179,222	6.88	15
16	Dishwashers					16
17	Maintenance Worker	5,466	5,819	80,398	13.82	17
18	Housekeepers	22,964	25,055	203,680	8.13	18
19	Laundry	2,916	3,198	36,379	11.38	19
20	Administrator	1,793	2,100	52,841	25.16	20
21	Assistant Administrator					21
22	Other Administrative	1,446	1,694	70,682	41.72	22
23	Office Manager					23
24	Clerical	13,273	14,597	216,859	14.86	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care Schedule 20A	2,423	2,925	69,889	23.89	32
33	Other(specify) Schedule 20A	9,599	10,541	130,586	12.39	33
34	TOTAL (lines 1 - 33)	238,552	263,448	\$ 3,026,061 *	\$ 11.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$		35
36	Medical Director	Monthly	4,800	L. 9 C. 3	36
37	Medical Records Consultant	Monthly	600	L. 10 C. 3	37
38	Nurse Consultant	1	28	L. 10 C. 3	38
39	Pharmacist Consultant	Monthly	600	L. 10 C. 3	39
40	Physical Therapy Consultant	227	10,928	L. 10a C.3	40
41	Occupational Therapy Consultant	156	8,060	L. 10a C.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	5	309	L. 10a C.3	43
44	Activity Consultant	7	802	L. 11 C. 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	396	\$ 26,127		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	2,307	\$ 86,773	L. 10 C. 3	50
51	Licensed Practical Nurses	1,289	40,883	L. 10 C. 3	51
52	Nurse Aides	17,144	376,810	L. 10 C. 3	52
53	TOTAL (lines 50 - 52)	20,740	\$ 504,466		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name

PROVIDER #

Period Ending

Meadows Mennonite Home

0011544

12/31/2001

Schedule 20A

XVIII. STAFFING AND SALARY COSTS

	Hours Worked	Hours Paid	Salary	Avg Hr Wage	Cost Report Line
Nursing Administration Secetary	2,040	2243	23,811	\$ 10.62	10
Chaplain	383	682	46,078	67.56	12
Total Line 32 - Other Health Care	2,423	2,925	\$ 69,889	\$ 23.89	
Development	976	1,128	31,082	27.55	43
Residential Services	7,224	7,958	85,610	10.76	43
Campus Director	1,088	1,144	10,373	9.07	43
Beautician	311	311	3,521	11.32	40
Total Line 33 - Other	9,599	10,541	\$ 130,586	\$ 12.39	

See Accountants' Compilation Report

Facility Name	Meadows Mennonite Home
PROVIDER #	0011544
Period Ending	12/31/2001

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	44,263
--	--------

Total (agree to Schedule V, line 19, column 8)	<u>44,263</u>
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See Accountants' Compilation Report

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

1	Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5 Amount of Expense Amortized Per Year								
					6 FY1998	7 FY1999	8 FY2000	9 FY2001	10 FY2002	11 FY2003	12 FY2004	13 FY2005	14 FY2006
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3	N/A												
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union No
- (2) Are there any dues to nursing home associations included on the cost report
If YES, give association name and amount Life Services Network - \$6,460 Yes
- (3) Did the nursing home make political contributions or payments to a political organization? No If YES, have these costs been properly adjusted out of the cost report N/A
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? N/A
- (5) Have you properly capitalized all major repairs and equipment purchases
What was the average life used for new equipment added during this period Yes
6.19
- (6) Indicate the total amount of both disposable and non-disposable diaper expenses and the location of this expense on Schedule V. 54,852 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation
- (8) Are you presently operating under a sale and leaseback arrangement No
If YES, give effective date of lease N/A
- (9) Are you presently operating under a sublease agreement _____ YES x NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO x If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took over N/A
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. 71,175
This amount is to be recorded on line 42 of Schedule V
- (12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? No If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V N/A
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B N/A For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount \$ 291
- (16) Travel and Transportation

a. Are there costs included for out-of-state travel No
If YES, attach a complete explanation

b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such program during this reporting period. N/A

c. What percent of all travel expense relates to transportation of nurses and patients? None

d. Have vehicle usage logs been maintained N/A

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period \$ N/A
- (17) Has an audit been performed by an independent certified public accounting firm Yes
Firm Name: Heinold-Banwart, Ltd. The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report N/A
Attach invoices and a summary of services for all architect and appraisal fees

	Salaries	Supplies	Other	Total	Reclass- ifications	Reclassified Total	Adjusted Adjustments	Adjusted Total
1. Dietary	313,745	15,460	2,046	331,251	0	331,251	0	331,251
2. Food Purchase	0	298,090	0	298,090	0	298,090	-291	297,799
3. Housekeeping	203,680	30,248	873	234,801	0	234,801	0	234,801
4. Laundry	36,379	9,581	17,349	63,309	0	63,309	0	63,309
5. Heat and Other Utilities	0	0	188,791	188,791	0	188,791	0	188,791
6. Maintenance	80,398	16,427	84,761	181,586	0	181,586	0	181,586
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	634,202	369,806	293,820	1,297,828	0	1,297,828	-291	1,297,537
9. Medical Director	0	0	4,800	4,800	0	4,800	0	4,800
10. Nursing & Medical Records	1,697,527	99,574	511,500	2,308,601	0	2,308,601	0	2,308,601
10a. Therapy	0	0	19,318	19,318	0	19,318	0	19,318
11. Activities	111,931	3,962	2,025	117,918	0	117,918	-2,023	115,895
12. Social Services	106,431	1,464	0	107,895	0	107,895	0	107,895
13. Nurse Aide Training	5,002	0	2,315	7,317	0	7,317	0	7,317
14. Program Transportation	0	0	0	0	0	0	0	0
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	1,920,891	105,000	539,958	2,565,849	0	2,565,849	-2,023	2,563,826
17. Administrative	123,523	0	0	123,523	0	123,523	0	123,523
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	44,263	44,263	0	44,263	0	44,263
20. Fees, Subscriptions & Promotion	0	0	19,928	19,928	0	19,928	0	19,928
21. Clerical & General Office	216,859	13,660	47,430	277,949	0	277,949	-13,378	264,571
22. Employee Benefits & Payroll	0	0	564,957	564,957	0	564,957	0	564,957
23. Inservice Training & Education	0	0	200	200	0	200	0	200
24. Travel and Seminar	0	0	24,746	24,746	0	24,746	-7,314	17,432
25. Other Admin. Staff Trans	0	0	7,582	7,582	0	7,582	0	7,582
26. Insurance-Prop.Liab.Malpractice	0	0	36,486	36,486	0	36,486	0	36,486
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	340,382	13,660	745,592	1,099,634	0	1,099,634	-20,692	1,078,942
29. Total General Administrative	2,895,475	488,466	1,579,370	4,963,311	0	4,963,311	-23,006	4,940,305
30. Depreciation	0	0	361,018	361,018	0	361,018	-15,102	345,916
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	143,822	143,822	0	143,822	-16,572	127,250
33. Real Estate	0	0	31,704	31,704	0	31,704	-31,704	0
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	760	760	0	760	0	760
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	537,304	537,304	0	537,304	-63,378	473,926
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	3,521	0	0	3,521	0	3,521	0	3,521
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	71,175	71,175	0	71,175	0	71,175
43. Other (specify):*	127,065	2,939	179,626	309,630	0	309,630	-309,630	0
44. Total Special Cost Ce	130,586	2,939	250,801	384,326	0	384,326	-309,630	74,696
45. Grand Total	3,026,061	491,405	2,367,475	5,884,941	0	5,884,941	-396,014	5,488,927

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	843,416	843,416
2. Cash - Patient Deposits	14,592	14,592
3. Accounts & Notes Recievable	258,683	258,683
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	96,311	96,311
7. Other Prepaid Expenses	33,743	33,743
8. Accounts Receivable-Owner/Related Party	11,213	11,213
9. Other (specify):	34,344	0
10. Total current assets	1,292,302	1,257,958
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	622,140	622,140
13. Land	217,622	42,098
14. Buildings, at Historical Cost	8,671,460	7,870,506
15. Leasehold Improvements, Historical Cost	0	0
16. Equipment, at Historical Cost	1,432,744	1,078,230
17. Accumulated Depreciation (book method)	-4,276,511	-4,222,744
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	1,148,571	505,001
23. other (specify):	0	0
24. Total Long-Term Assets	7,816,026	5,895,231
25. Total Assets	9,108,328	7,153,189
CURRENT LIABILITIES		
26. Accounts Payable	75,082	75,082
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	18,285	18,285
29. Short-Term Notes Payable	321,507	321,507
30. Accrued Salaries Payable	134,211	134,211
31. Accrued Taxes Payable	-29	-29
32. Accrued Real Estate Taxes	31,700	0
33. Accrued Interest Payable	29,367	29,357
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	276,987	276,987
37. Other Current Liabilities (specify):	10	10
38. Total Current Liabilities	887,120	855,410
LONG TERM LIABILITES		
39. Long-Term Notes Payable	427,071	427,071
40. Mortgage Payable	2,393,940	2,393,940
41. Bonds Payable	0	0
42. Deferred Compensation	0	0
43. Other Long-Term Liabilities (specify):	873,722	0
44. Other Long-Term Liabilities (specify):	0	0
45. Total Long-Term Liabilities	3,694,733	2,821,011
46. Total Liabilities	4,581,853	3,676,421
47. Total Equity	4,526,475	3,476,768
48. Total Liabilities and Equity	9,108,328	7,153,189

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	5,653,136
2. Discounts and Allowances for all Levels	-595,001
Subtotal - Inpatient Care	5,058,135
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	22,127
7. Oxygen	0
Subtotal - Anciliary Revenue	22,127
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	7,720
14. Non-Patient Meals	291
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiology and X-Ray	0
21. Other Medical Services	97,917
22. Laundry	0
Subtotal - Other Operating Revenue	105,928
24. Contributions	0
25. Interest and Other Investments Income	21,822
Subtotal - Non-Operating Revenue	21,822
27. Other Revenue (specify):	485,059
28. Other Revenue (specify):	0
Subtotal - Other Revenue	485,059
30. Total Revenue	5,693,071
31. General Services	1,297,828
32. Health Care	2,565,849
33. General Administration	1,099,634
34. Ownership	537,304
35. Special Cost Centers	313,151
35. Provider Participation Fee	71,175
37. Other	0
40. Total Expenses	5,884,941
41. Income Before Income Taxes	-191,870
42. Income Taxes	0
43. Net Income or Loss for the Year	-191,870

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10 Attachment of Real Estate Bill and fill out form

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12 P12 does not show totals, it carries to P12a, therefore P12a must always be attached

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19 The bottom right side of page under **, you must write in any comments

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RECONCILIATION REPORT

Meadows Mennonite Ho

03:29 PM

11/07/05

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CELL	SUB- SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB- SCHED.	LINE NO.	COL. NO.
Adjustment Detail	-396,014	equal to	-396,014	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	127,250	equal to	127,250	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	345,916	equal to	345,916	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	760	equal to	760	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	7,317	equal to	7,317	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	19,297	equal to	19,318	-21	FAILED	Pg16 Z12+Z14..Z16 & Pg 20 X17..X20	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	10a	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	1,297,828	equal to	1,297,828	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	2,565,849	equal to	2,565,849	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	1,099,634	equal to	1,099,634	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	537,304	equal to	537,304	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	313,151	equal to	313,151	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	71,175	equal to	71,175	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	1,655,176	equal to	1,697,527	-42,351	FAILED	Pg20 K11..K15+K35+K36+K38..K44	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	5,002	< or = to	5,002	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to	0	0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	111,931	equal to	111,931	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	60,353	equal to	106,431	-46,078	FAILED	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	313,745	equal to	313,745	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	80,398	equal to	80,398	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	203,680	equal to	203,680	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	36,379	equal to	36,379	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	123,523	equal to	123,523	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	216,859	equal to	216,859	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to	0	0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	3,026,061	equal to	3,026,061	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to	2,046	-2,046	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	4,800	< or = to	4,800	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	505,694	< or = to	511,500	-5,806	O.K.	Pg20 X14..X16+X37..X39	B. & C.	7to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	802	< or = to	2,025	-1,223	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	0	< or = to	0	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	123,523	equal to	123,523	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	44,263	equal to	44,263	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	564,957	equal to	564,957	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	19,928	equal to	19,928	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	17,432	equal to	17,432	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	71,175	equal to	71,175	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	0	< or = to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	0	equal to	0	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	5,002	equal to	5,002	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	3,142,518	equal to	3,142,518	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	0	equal to	0	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	42,098	equal to	42,098	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	7,870,506	equal to	7,870,506	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	1,078,230	equal to	1,078,230	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	4,222,744	equal to	4,222,744	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	4,526,475	equal to	4,526,475	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	-191,870	equal to	-191,870	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to	0	0	O.K.	Pg22 F31-J31..S31	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	9,108,328	equal to	9,108,328	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1